NEW YORK STATE | Office of Addiction Services and Supports

Guidance for Screening, Assessment, Intervention, and Monitoring for Suicide Risk and Overdose Risk in OASAS Certified Programs

www.oasas.ny.gov

Table of Contents

Introduction

Suicide and overdose on alcohol and drugs are significant public health issues in New York State (NYS) and across the country. Individuals with substance-related and addictive disorders have been shown to have an elevated risk for suicide attempts and death by suicide and it is not always clear if a death in this population is due to an intentional suicide attempt or accidental overdose.

To address suicide risk and overdose risk for individuals with substance-related and addictive disorders, the NYS Office of Addiction Services and Supports (OASAS) is implementing screening, assessment, intervention, and monitoring for both suicide and overdose risk in certified programs. **Table 1 on page 13 identifies the OASAS certified programs that are required to follow this Guidance. OASAS programs not listed in Table 1 are encouraged but not required to follow this Guidance.**

This Guidance provides information about:

1. Screening for suicide risk and overdose risk.
2. Assessing the need for an acute evaluation at an emergency department (ED) or comprehensive emergency psychiatric program (CPEP) based on the results of screenings.
3. Creating safety plans based on the results of screenings for suicide risk and overdose risk.
4. Providing referrals for comprehensive mental health assessments.
5. Monitoring those at elevated risk for suicide and/or overdose; and
6. Training resources for implementing these guidelines.

Screening versus Assessment

For the purposes of this Guidance, *screening* is a process for identifying patients who may be at risk for suicide and/or overdose by administering a screening instrument or asking screening questions. Screening should take place when an adult or adolescent is newly admitted or readmitted to an OASAS certified program. Screening can be completed by any clinical staff member, including licensed medical staff, credentialed or licensed staff, non-credentialed staff, and student interns, who have been trained to administer screening instruments and ask screening questions. An *assessment*, however, can only be performed by licensed practitioners working within their scope of practice (to be termed "licensed practitioners" for the rest of this document). If there is a question about what qualifications are needed to perform a screening, a licensed practitioner should administer the screening instruments and ask the screening questions.

Accessing Screening Instruments

OASAS regulations require that all patients treated in OASAS certified programs are screened on admission for mental health conditions that may co-occur with substance use disorders using validated screening instruments. The Guidance for the Use of Screening Instruments for Co-occurring Mental Health Conditions, issued by OASAS in October 2020, describes the requirements for screening and provides tables of OASAS approved mental health screening instruments for adults and adolescents. Unless otherwise stated, all screening instruments described in this document can be accessed through the Guidance link.

Screening, Assessment, and Intervention for Suicide Risk

Although other validated screening instruments for identifying general mental health conditions that may occur with substance-related and addictive disorders in adults are listed in the Guidance for the Use of Screening Instruments for Co-occurring Mental Health Conditions, OASAS certified programs are encouraged to screen all adult patients with the Modified Mini Screen (MMS). The MMS asks questions about multiple mental health domains. Question 4 specifically asks, "In the past month, did you think that you would be better off dead or wish you were dead?" Any patient who answers "Yes" to question 4 on the MMS should be screened by a trained clinical staff member with the Columbia Suicide Severity Risk Scale (C-SSRS), a brief questionnaire that rates suicide risk. Patients who are rated by the C-SSRS as low or moderate risk for suicide should be referred for a comprehensive mental health evaluation by a licensed practitioner as soon as feasible. Patients who are rated as high risk for suicide should be placed on suicide safety precautions and must meet immediately with a licensed practitioner for a suicide risk assessment on-site or at an ED/CPEP. If the patient answers "No" to question 4 on the MMS, the C-SSRS does not need to be completed.

Another option for suicide risk screening that is not listed in the adult table of the Guidance on Screening Instruments for Co-occurring Mental Health Conditions is the Ask Suicide-Screening Questions (ASQ; NIMH » Ask Suicide-Screening Questions (ASQ) Toolkit (nih.gov), a validated five question screening instrument developed by the National Institutes of Mental Health (NIMH) that can be administered to adults or adolescents. A "Yes" response to any of the first four questions is considered a positive screen and requires asking question 5 -- "Are you having thoughts of killing yourself right now?" Patients who say "Yes" to any of the first four questions and "Yes" to question 5 will need a suicide risk assessment immediately by a licensed practitioner as well as implementation of suicide safety precautions. A "No" response to question 5 requires a suicide risk assessment by a licensed practitioner.

The other validated general mental health screening instruments for adults listed in the OASAS Guidance for the Use of Screening Instruments for Co-occurring Mental Health Conditions, the Mental Health Screening Form III (MHSF-III) and the Kessler Distress Scale, both the six question (K6) and the ten question (K10) versions, do not have questions about suicidal thoughts. If a program chooses to administer the MHSF-III, the K6 or the K10 as the only general mental health screening instrument, the program must also administer the C-SSRS or the ASQ.

The MMS is not validated for individuals under 18 years of age and a comparable adolescent version is not available in the public domain. As described in the OASAS Guidance for the Use of Screening Instruments for Co-occurring Mental Health Conditions, recommended general mental health screens for adolescents that a trained clinical staff member can administer are the Pediatric Symptom Checklist 17 Youth (PSC-17-Y) and the Strengths and Difficulties Questionnaire (SDQ 17+). Since these screening instruments do not have questions about suicide, the C-SSRS or the ASQ must be administered by a trained clinical staff member to all adolescents. An adolescent with a C-SSRS rating of low or moderate risk for suicide should be referred for a comprehensive mental health evaluation by a licensed practitioner as soon as feasible. An adolescent with a C-SSRS rating high risk for suicide or a "Yes" response to Question 5 on the ASQ should be placed on suicide safety precautions and must meet immediately with a licensed practitioner for a suicide risk assessment on-site or at an ED/CPEP.

It is important to note that the clinical staff member administering screening instruments to an adult or an adolescent can request a suicide risk assessment and put suicide safety precautions in place if they are concerned that the patient is at elevated risk for suicide, even if the patient's responses on the general mental health screening instruments, C-SSRS or ASQ do not indicate a suicide risk.

One option for performing a suicide assessment for both adults and adolescents is to utilize NIMH's Brief Suicide Safety Assessment (BSSA bssa_worksheet_outpatient_adult_asq_nimh_toolkit_160673.pdf (nih.gov). In addition to questions about frequency of suicidal thoughts, current suicide plan and past suicidal behavior, the BSSA also assesses mental health symptoms that may be associated with an elevated risk of suicide and gathers information about the patient's social supports and current stressors. OASAS certified programs are not required to use the BSSA to perform a suicide assessment and they may use any suicide assessment process or tool of their choosing based on the requirements of regulatory and accreditation bodies, and the program's policies and procedures.

After assessment, immediate referral to an ED or CPEP for an acute mental health evaluation should occur for any adult or adolescent in an inpatient rehabilitation, residential, or outpatient setting who is determined to be at imminent risk for suicide based on the clinical judgment of the licensed practitioner. If the licensed practitioner is uncertain if an acute mental health evaluation is necessary or if no licensed practitioner is available to assess the patient for suicide risk after the screening process, the program should err on the side of caution and send the patient to an ED or CPEP. If a patient does not require an acute mental health evaluation at an ED or CPEP, the Stanley-Brown Suicide Safety Plan should be completed, lethal means counseling provided, and an appointment for a comprehensive mental health evaluation be made for the patient for as soon as possible.

The Stanley-Brown Suicide Safety Plan (Brown_StanleySafetyPlanTemplate.pdf (sprc.org)) is completed in collaboration with the adult or adolescent and a clinical staff member or licensed practitioner who has been trained in developing suicide safety plans. With adolescents, the clinical staff member or licensed practitioner should discuss including a caregiver such as a parent, other relative or legal guardian, or others in their support system in suicide safety planning and use their clinical judgment as well as the adolescent's preference when determining if a caregiver should be involved. Similarly, adults may choose and consent to have family or others from their support system involved in creating their Plan. Clinical judgment should be exercised in conjunction with the adult patient's wishes to determine if involving family or supportive others is appropriate.

The goal of the Suicide Safety Plan is to create a list of strategies the patient can use to decrease their risk of engaging in suicidal behaviors. The six steps of the Suicide Safety Plan are:

1. Recognizing the warning signs of an impending suicidal crisis.
2. Using coping strategies.
3. Contacting others to distract from suicidal thoughts.
4. Contacting family members or friends who may help to resolve the crisis.
5. Contacting mental health professionals or agencies; and
6. Reducing the availability of means to complete suicide

The patient should receive the original version of the Suicide Safety Plan and a copy placed in the patient's medical record. The clinical staff member or licensed practitioner who worked with the

patient on the Plan should discuss potential barriers to using the Plan, where the patient will keep the Plan, and how they will retrieve it in a crisis. The discussion should also determine if having copies of the Plan to keep in several locations or to give to others in their support system would be helpful. Other options for ensuring that the patient has ready access to the Plan is to change the size or format so it can be placed in a wallet or stored on an electronic device as a file or picture.

Once the Suicide Safety Plan is completed, the clinical staff member or the licensed practitioner should perform lethal means counseling. Lethal means counseling is an integral part of suicide safety planning because it assesses whether an adult or adolescent at moderate or high risk for suicide has access to firearms, medications, or other potentially lethal substances or objects. If lethal means are identified, the clinical staff member or licensed practitioner trained in this counselling modality can engage the patient, and, if available and with the patient's consent, family members and/or others in their support system in a discussion of how to remove or limit access to these means. While there is no standardized form or templated note used to conduct and document lethal means counseling, the clinical staff member or licensed practitioner should document in the patient's medical record the individuals involved in the lethal means counseling, the lethal means identified, and the plan to reduce access. A copy of the plan to identify and remove lethal means should be provided to the patient, with copies provided to family, legal guardians and/or others in the patient's support system, with the patient's consent.

Screening, Assessment, and Intervention for Overdose Risk

All adults and adolescents should be screened by a trained clinical staff member for a history of alcohol and/or drug overdose. One way to screen for history of overdose is to ask the following: *"In your lifetime, have you ever overdosed on alcohol or drugs unintentionally?"* If the patient needs more information about what constitutes an overdose the following definition may be used: "*"When the use of a drug or drugs, including alcohol, overwhelms your body and you cannot respond to others or breathe adequately resulting in Narcan/naloxone rescue and/or emergency medical help."* If the patient responds "Yes," the patient is considered to have an elevated risk for a future overdose, even if the reported overdose was in the distant past. Follow-up questions about overdose history include "When was the last time you overdosed?" and "How many times have you overdosed in your lifetime?" Information about the substance(s) involved in and any medical or psychiatric interventions because of the overdose(s) should be gathered during the screening. Follow-up questions are not required if the patient answers "No" to the lifetime overdose screening question. There is no validated screening instrument for overdose history and these overdose questions must be incorporated into other patient screening protocols and processes for adults and adolescents.

An elevated risk for overdose may exist even if the patient has no history of unintentional overdose. Other risk factors for unintentional overdose include:

- Using alone.
- Using opioids.
- Using substances intravenously.
- Using substances that may be adulterated with fentanyl or other opioids such as stimulants, benzodiazepines, MDMA, etc.
- Using sedating substances such as alcohol, benzodiazepines, and opioids at the same time.

- Using stimulants such as cocaine and methamphetamine with opioids.
- Having lung, heart, liver, or kidney conditions, or HIV.
- Having been released from jail or prison recently.

Adults or adolescents who have any of these risk factors but deny a history of unintentional overdose also should be considered at elevated risk for overdose.

If an adult or an adolescent reports an overdose within the last forty-eight hours and has not received a medical evaluation already, a licensed practitioner should assess the patient to determine if a medical evaluation at an ED for any possible physical consequences from the overdose is necessary. If a licensed practitioner is unavailable, or is uncertain if an acute medical assessment is necessary, the program should err on the side of caution and send the patient to an ED.

If the results of other screenings do not indicate that the adult or adolescent needs an immediate evaluation at an ED/CPEP because of possible medical consequences due to a recent overdose and has been identified as having an elevated risk for overdose, an Overdose Safety Plan should be completed by a trained clinical staff member, and a referral for a comprehensive mental health assessment with a licensed practitioner scheduled for the patient as soon as feasible.

The Overdose Safety Plan, developed by Thomas McCarry, LMHC, and Virna Little, PsyD, LCSW-r of Zero Overdose (https://www.zerooverdose.org) is created by a trained clinical staff member working collaboratively with the adult or adolescent. The Overdose Safety Plan addresses:

1. Personal risk factors for accidental overdose.
2. Actions to reduce overdose risk.
3. Activities to maintain physical and mental health.
4. Identification of individuals, including professionals, and agencies who can provide support.
5. Identification of one reason for living that day; and
6. Next steps to reduce accidental overdose risk

The adult or adolescent may consent to have family or others in their support system involved when the Overdose Safety Plan is created. The clinical staff member should use their clinical judgment in conjunction with the patient's request when determining the appropriateness of having others involved in developing the Overdose Safety Plan.

The patient should receive the original version of the Overdose Safety Plan and a copy placed in their medical record. The clinical staff member who collaboratively developed the Plan with the patient should discuss where the patient will keep the Plan and how they will retrieve when needed. The discussion should also address whether having copies of the Plan that they can keep in several locations or to give to supportive others would be helpful. One option for ensuring the patient has ready access to the Plan is to change the size or format so it can be placed in a wallet or stored on an electronic device as a file or picture.

Other Information about Safety Planning for Suicide Risk and Overdose Risk

Based on the outcomes of the screenings and assessments, the clinical staff member or licensed practitioner may complete one or two safety plans in collaboration with the adult or adolescent. Since there may be a certain amount of overlap in the questions asked and information gathered between the

two safety plans, developing the two plans may be coordinated to avoid repeated inquires. In this instance, the clinical staff member or licensed practitioner may transcribe or have the patient transcribe information obtained for one safety plan directly onto the other safety plan.

Another important part of safety planning for suicide and overdose is providing adults and adolescents, and others in their support system when appropriate, with contact information for crisis services, including:

1. The National Suicide Prevention Lifeline (1-800-273-TALK/8255; Lifeline (suicidepreventionlifeline.org);
2. The NYS Crisis Text Line (Text GOT5 to 741741):
3. The OASAS HOPEline (1-877-8-HOPENY or text HOPENY);
4. Never Use Alone for those at risk of overdose (1-800-484-3731; https://neverusealone.com);
5. Crisis services in their local community

Patients and their supports should be encouraged to enter one or more of the crisis services numbers in their cell phone so they may access them rapidly if needed. Additionally, patients and their supports should be reminded to call 911 or go to their nearest ED/CPEP in the event of a mental health emergency.

Referral for Comprehensive Mental Health Assessments

In addition to creating safety plans with all adults and adolescents identified as being at moderate or high risk for suicide and at risk for overdose, the clinical staff member should refer the patient to a licensed practitioner for a comprehensive mental health assessment. For inpatient and residential services, the patient would see a licensed practitioner who works for the service as soon as possible. In the outpatient setting, a patient who has an established relationship with a licensed practitioner in the program or the community should be scheduled for a follow-up appointment with that practitioner for as soon as possible. Patients without an established licensed practitioner should be referred to a licensed practitioner in-program or at an outside mental health agency.

Interventions and Monitoring for Suicide Risk and Overdose Risk

All OASAS certified programs must create policies and procedures for interventions and monitoring adults and adolescents who have been identified as being at moderate or high risk for suicide and at risk for overdose. These policies and procedures will differ depending on the treatment setting.

Inpatient Services and Residential Programs

Inpatient and residential programs should designate a clinical staff member with primary responsibility for ensuring that all elements of intervention and monitoring take place. Policies and procedures for intervention and monitoring adults and adolescents during and after admission to an inpatient service or a residential program are:

1. Reassessing the patient's suicide and/or overdose risk during admission.
2. Developing treatment plans that include interventions to mitigate identified risk factors for suicide and/or overdose.
3. Developing the Suicide and/or Overdose Safety Plans in collaboration with the patient

a. Patients at moderate or high risk for suicide should receive lethal means counseling
b. Overdose prevention education should be provided to all patients at risk for overdose regardless of substances used or intended to be used
c. Education about naloxone and the provision of naloxone kits or prescriptions to patients regardless of substance use disorder diagnosis, time since last use, and substance of intended use
d. Provision of fentanyl test strips/other drug testing strips and education on their use, or information about how to obtain testing strips should be provided to all patients at risk for overdose on opioids or drugs that may be adulterated with fentanyl such as opioids, stimulants, benzodiazepines, MDMA, etc.

4. Rescreening patients at moderate and high risk for suicide with the C-SSRS prior to discharge
5. Reviewing and revising, if needed, the Suicide and/or Overdose Safety Plans prior to discharge
    a. Contact information for national and local crisis services should be included in all plans
6. Scheduling a mental health appointment with a licensed practitioner within seventy-two hours of discharge
7. Contacting the patient within twenty-four to seventy-two hours of discharge to:
    a. Perform a brief risk assessment for suicide and/or overdose
    b. Revise Safety Plans if needed based on the brief risk assessment
    c. Help resolve any challenges to attending the scheduled mental health appointment
8. Contacting the patient on the day of the scheduled mental health appointment to ensure the patient has attended and helping the patient reschedule a missed appointment if needed; and
9. Contacting the patient at regularly scheduled times post-discharge until the patient has attended the mental health appointment or the patient requests that the contacts end.

When any patient is referred from the inpatient or residential service to outpatient substance use disorder and/or mental health treatment, a written consent must be signed by the patient according to all relevant state and federal confidentiality requirements, including 42 CFR Part 2, before the referral can be made, and any treatment records, which should include any safety plans, are sent.

Outpatient Programs

Outpatients identified as moderate or high risk for suicide and/or at risk for overdose should have an identified clinical staff member who has primary responsibility for ensuring that all elements of intervention and monitoring take place. When developing policies and procedures, elements for intervention and monitoring for those at moderate or high risk for suicide and/or at risk for overdose in outpatient programs are:

1. Developing the Suicide and/or Overdose Safety Plans in collaboration with the patient.
    a. Patients at moderate or high risk for suicide should receive lethal means counseling.
    b. Overdose prevention education should be provided to all patients at risk for overdose regardless of substance used or intended to be used; and
    c. Education about naloxone and the provision of naloxone kits or prescriptions to patients regardless of substance use disorder diagnosis, time since last use, and substance of intended use.
    d. Provision of fentanyl test strips/other drug testing strips and education on their use, or information about how to obtain testing strips should be provided to all patients at risk

for overdose on opioids or drugs that may be adulterated with fentanyl such as stimulants, benzodiazepines, MDMA, etc.

2. Developing treatment plans that include interventions to mitigate identified risk factors for suicide and/or overdose.
3. Meeting with the patient weekly in person, by video, or by telephone to:
    a. Review the use of Safety Plans.
    b. Revise Safety Plans as needed; and
    c. Review attendance at scheduled mental health, medical, and social services appointments.
4. Contacting the patient on the same day if they miss a scheduled appointment with an outpatient clinic provider.
5. Contacting the patient if they stop engaging in mental health, medical, and/or social services.
6. Contacting individuals in the patient's support system, with the patient's written consent, when assistance is needed to keep the patient engaged or to help the patient reengage in treatment.

Additionally, the intervention and monitoring policies and procedures should address the development of a list of outpatients identified as high risk for suicide and/or overdose; the provision of supervision to clinical staff members working with patients at high risk; the determination of a schedule of regular multidisciplinary case conferences to discuss patients on the high risk lists; the development of criteria for removing the patient from or placing them back on high risk lists for suicide and/or overdose. It is recommended that all patients in outpatient programs are screened quarterly for suicide risk and overdose risk.

If an adult or adolescent cannot receive mental health treatment at the outpatient substance use disorder treatment program and is referred instead to an outside mental health provider, a written consent must be signed by the patient according to all relevant state and federal confidentiality requirements, including 42 CFR Part 2, before the referral can be made, or any records sent to the outside mental health provider.

Trainings for Screening, Assessment, Intervention and Monitoring for Suicide Risk and Overdose Risk for OASAS Certified Programs

As described in the Guidance for the Use of Screening Instruments for Co-occurring Mental Health Conditions, OASAS certified programs must develop policies and procedures for training clinical staff members to administer and score the adult and adolescent screening instruments for co-occurring mental health conditions. Although web-based trainings in the public domain are not available for the general screening instruments for adults – the Modified Mini Screen (MMS), the Mental Health Screening Form III (MHSF-III) and the Kessler Distress Scales (K6 and K10) – or adolescents -- the Pediatric Symptom Checklist 17 Youth (PSC-17-Y) and the Strengths and Difficulties Questionnaire (SDQ 17+) – the links to the screening instruments in the Guidance provide general information about the instruments as well as scoring guidance.

Trainings in the use of the C-SSRS are available at no cost through The Columbia Lighthouse Project (C-SSRS Screener Training - English (USA) - YouTube). The Center for Practice Innovations (CPI) provides trainings on suicide screening, assessment, intervention, and monitoring and are available at no cost. A full list of CPI trainings for suicide screening, assessment, intervention and monitoring can be found at Overview (practiceinnovations.org) and a list of recommended trainings for administering the

Columbia Suicide Severity Risk Scale (C-SSRS), creating the Stanley-Brown Suicide Safety Plan, and monitoring suicide risk can be found in Table 4 on page 17.

Videos created by NIMH that demonstrate the administration of the Ask Suicide Questions (ASQ) for adolescents can be found at Suicide Risk Screening Training: How to Use the ASQ to Detect Patients at Risk for Suicide - YouTube. The NIMH website also provides a training for administering the Brief Suicide Safety Assessment (BSSA) -- Suicide Risk Screening Training: How to Manage Patients at Risk for Suicide - YouTube. Lastly, training on lethal means counseling can be found at the Zero Suicide website: Counseling on Access to Lethal Means (edc.org)

A recording of the live webinar training for the Overdose Safety Plan Intervention that took place in January 2022 may be accessed through the MCTAC website by clicking here. **Completion of the training by attending the live webinar or watching the recording of the recording is required to access the Overdose Safety Plan at the Zero Overdose website (**https://www.zerooverdose.org**)**. Virtual trainings for Opioid Overdose Prevention may be found at Search | Office of Addiction Services and Supports (ny.gov)**.**

Trainings should be completed by all new clinical staff members when they are hired and each year thereafter. Providers shall maintain a log of staff training.

Questions about this Guidance should be sent to PICM@oasas.ny.gov

Table 1: OASAS Certified Programs Required to Implement Screening, Assessment, Intervention and Monitoring for Suicide Risk and Overdose Risk

Inpatient Services	
Part 816	Medically Managed Withdrawal and Stabilization Services
	Medically Supervised Withdrawal and Stabilization Services
	Medically Monitored Withdrawal and Stabilization Services
	Observation Beds
Part 818	Substance Use Disorder Inpatient Rehabilitation Services
Residential Services	
Part 817	Residential Rehabilitation Services for Youth
Part 819	Intensive Residential Rehabilitation Services
Part 820	Residential Stabilization Services
	Residential Rehabilitation Services
Outpatient Services	
Part 816	Medically Monitored Outpatient Services
Part 822	Substance Use Disorder Outpatient Rehabilitation Services
	Substance Use Disorder Outpatient Programs

Table 2: Summary of Guidance for Screening, Assessment, Intervention and Monitoring Patients with Suicide Risk

Setting	Screening	Assessment	Intervention	Monitoring
Inpatient	**Adults:** Modified Mini Screen (MMS) then Columbia-Suicide Severity Rating Scale (C-SSRS) or Ask Suicide Questions (ASQ) if "Yes" response to MMS Question 4. **Adolescents**: C-SSRS or ASQ	**Adults and Adolescents**: Immediately complete a suicide risk assessment* if high risk for suicide is identified. Continue assessing suicide risk throughout inpatient admission Administer C-SSRS prior to discharge.	**Adults and Adolescents**: Complete Stanley-Brown Suicide Safety Plan if at moderate or high risk for suicide. Provide lethal means counselling. Provide contact information for national and local crisis intervention services. With consent, include family and/or supportive others in Safety Planning and lethal means counseling.	**Adults and Adolescents**: Schedule an appointment with a mental health practitioner within 72 hours of discharge. Complete one contact by telephone, video, text, or email within 24 to 72 hours of discharge. Contact at regular intervals until the patient has attended mental health appointment.
Outpatient	**Adults:** MMS then C-SSRS or ASQ if "Yes" response to MMS Question 4. **Adolescents**: C-SSRS or ASQ	**Adults and Adolescents**: Immediately complete a suicide assessment* if high suicide risk identified. Refer to ED/CPEP for acute psychiatric evaluation if at imminent risk; otherwise refer to licensed mental health practitioner for	**Adults and Adolescents**: Complete Stanley-Brown Suicide Safety Plan if at moderate or high risk for suicide. Provide lethal means counselling.	**Adults and Adolescents**: Schedule an appointment with a licensed mental health practitioner. Weekly meetings to review use of Safety Plan and to revise as needed. Contact on the same day after missed appointments

		comprehensive mental health evaluation.	Provide contact information for national and local crisis intervention services. With consent, include family and/or supportive others in safety planning.	and/or contact after disengagement from other treatment services.
Residential	**Adults:** MMS then C-SSRS or ASQ if "Yes" response to MMS Question 4. **Adolescents**: C-SSRS or ASQ	**Adults and Adolescents**: Immediately complete a suicide risk assessment* if high risk for suicide identified. Refer to ED/CPEP for acute psychiatric evaluation if at imminent risk of suicide; otherwise refer to licensed mental health practitioner for comprehensive mental health evaluation. Continue assessing suicide risk throughout residential admission.	**Adults and Adolescents**: Complete Stanley-Brown Suicide Safety Plan for those at moderate or high risk. Provide lethal means counselling. Provide contact information for national and local crisis intervention services. With consent, include family and/or supportive others in Safety Planning and lethal means counseling.	**Adults and Adolescents:** Schedule an appointment with a licensed mental health practitioner within 72 hours of discharge. Complete one contact by telephone, video, text, or email within 48 hours of discharge. Contact at regular intervals until the patient has attended the mental health appointment.

*Must be completed by a licensed practitioner working within their scope of practice

Table 3: Summary of Guidance for Screening, Assessment, Intervention and Monitoring Patients with Overdose Risk

Setting	Screening	Assessment	Intervention	Monitoring
Inpatient	**Adults and Adolescents:** Ask: "In your lifetime, have you ever overdosed on alcohol or drugs unintentionally?" If "Yes" ask: "When was the last time you overdosed?" and "How many times in your life have you overdosed?" Ask about substances involved in overdose and if medical attention was needed. Ask about other risk factors for overdose listed on pages 6 and 7 if the adult or adolescent denies a history of unintentional overdose.	**Adults and Adolescents**: Complete a medical assessment* if overdose has occurred in the last 48 hours. **Adults and Adolescents:** Continue gathering information about overdose history during the inpatient admission.	**Adults and Adolescents**: Complete Overdose Safety Plan. Provide overdose prevention education and a naloxone kit/prescription. Provide contact information for national and local crisis intervention services. With consent, include family and/or supportive others in Safety Planning.	**Adults and Adolescents**: Schedule an appointment with a licensed mental health practitioner within 72 hours of discharge. Complete one contact by telephone, video, text, or email within 24 to 72 hours of discharge. Contact at regular intervals until the patient has attended scheduled mental health appointment.
Outpatient	**Adults and Adolescents:** Ask: "In your lifetime, have you ever overdosed on alcohol or drugs unintentionally?" If "Yes" ask: ""When was the last time you overdosed?" and "How many times in your life have you overdosed?" Ask about substances involved in overdose and if medical attention was needed. Ask about other risk factors for overdose listed on pages 6 and 7 if the adult or adolescent denies a history of unintentional overdose.	**Adults and Adolescents**: Complete an immediate medical assessment* if overdose has occurred in the last 48 hours. Refer to ED for acute medical evaluation if overdose has occurred within the last 48 hours and the patient has not received a medical evaluation; otherwise refer to a licensed mental health practitioner* for comprehensive mental health evaluation.	**Adults and Adolescents**: Complete Overdose Safety Plan. Provide overdose prevention education and a naloxone kit/prescription. Provide contact information for national and local crisis intervention services. With consent, include family and/or supportive others in Safety Planning.	**Adults and Adolescents**: Schedule an appointment with a licensed mental health practitioner. Weekly meetings to review use of Overdose Safety Plan and to revise as needed. Contact on the same day after missed appointments and/or contact after disengagement from other treatment services.

Residential	**Adults and Adolescents:** Ask: "In your lifetime, have you ever overdosed on alcohol or drugs unintentionally?" If "Yes" ask: "How many times in your life have you overdosed" and "When was the last time you overdosed." Ask about substances involved in overdose and if medical attention was needed. Ask about other risk factors for overdose listed on pages 6 and 7 if the adult or adolescent denies a history of unintentional overdose.	**Adults and Adolescents**: Complete an immediate medical assessment* if overdose has occurred in the last 48 hours. Refer to ED for acute medical evaluation if overdose has occurred within the last 48 hours and the patient has not received a medical evaluation; otherwise refer to licensed mental health practitioner* for comprehensive mental health evaluation.	**Adults and Adolescents**: Complete Overdose Safety Plan. Provide overdose prevention education and a naloxone kit/prescription. Provide contact information for national and local crisis intervention services. With consent, include family and/or supportive others in Safety Planning.	**Adults and Adolescents:** Schedule an appointment with a licensed mental health practitioner within 72 hours of discharge. Complete one contact by telephone, video, text, or email within 24 to 72 hours of discharge. Contact at regular intervals until the patient has attended the mental health appointment.

*Must be completed by a licensed practitioner working within their scope of practice

Table 4: Trainings for Screening, Assessment, Intervention and Monitoring for Suicide and Overdose Risk for OASAS Certified Programs

	Source	Training	Format	Link
Suicide Screening and Assessment	***The Columbia Lighthouse Project***	C-SSRS Screener Training	Prerecorded Webinar	C-SSRS Screener Training - English (USA) - YouTube
	Center for Practice Innovation (CPI)	Comprehensive Suicide Risk Assessment	Online Webinar	Comprehensive Suicide Risk Assessment ©2016 (csod.com)
	National Institute for Mental Health (NIMH)	Ask Suicide-Screening Questions (ASQ)	Prerecorded Webinar	Suicide Risk Screening Training: How to Use the ASQ to Detect Patients at Risk for Suicide - YouTube
		Brief Suicide Screening Assessment (BSSA)	Prerecorded Webinar	Suicide Risk Screening Training: How to Manage Patients at Risk for Suicide - YouTube
Suicide Safety Planning	***Center for Practice Innovation (CPI)***	Safety Planning for Suicide Prevention	Online Webinar	Safety Planning Intervention for Suicide Prevention ©2013 (csod.com)
	Zero Suicide	Lethal Means Counseling	Online Webinar	Counseling on Access to Lethal Means (edc.org)
Suicide Risk Monitoring	***Center for Practice Innovation (CPI)***	Structured Follow-up and Monitoring	Online Webinar	Structured Follow-up and Monitoring ©2015 (csod.com)
Overdose Safety Planning	***Zero Overdose***	The Overdose Safety Planning Intervention	Live Webinar on January 20, 2022 or recording of the Webinar	Recorded Webinar may be accessed through the MCTAC website by clicking here
Opioid Overdose Prevention Training	***OASAS***	Virtual Opioid Overdose Prevention Training	Online Webinar	Search | Office of Addiction Services and Supports (ny.gov)